Diagnostic and Statistical Manual of Mental Disorders

The ***Diagnostic and Statistical Manual of Mental Disorders*** (**DSM**), published by the American Psychiatric Association (APA), offers a common language and standard criteria for the classification of mental disorders. It is used, or relied upon, by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies, the legal system, and policy makers together with alternatives such as the ICD-10 Classification of Mental and Behavioural Disorders, produced by the WHO.[1]

The DSM is in its fifth edition, the DSM-5, published on May 18, 2013. The DSM evolved from systems for collecting census and psychiatric hospital statistics, and from a United States Army manual. Revisions since its first publication in 1952 have incrementally added to the total number of mental disorders, and removed those no longer considered to be mental disorders.

The International Classification of Diseases (ICD) is the other common manual for mental disorders. It has broader scope than the DSM, covering overall health. While the DSM is the most popular diagnostic system for mental disorders in the US, the ICD is used more widely in Europe and other parts of the world, giving it a far larger reach than the DSM. The DSM-IV-TR (4th. ed.) contains specific codes allowing comparisons between the DSM and the ICD manuals, which may not systematically match because revisions are not simultaneously coordinated.[2] Though recent editions of the DSM and ICD have become similar due to collaborative agreements, each one contains information absent from the other.[3]

The DSM has received praise for standardizing psychiatric diagnosis grounded in empirical evidence (as opposed to a theory-bound nosology) since DSM-III, but it also generated controversy and criticism. Related critiques include ongoing questions concerning the reliability and validity of many diagnoses; the use of arbitrary dividing lines between mental illness and "normality"; possible cultural bias; and the medicalization of human distress.[4][5][6][7][8]

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Uses and definition

Mental health professionals use the manual to determine and help communicate a patient's diagnosis after an evaluation. Hospitals, clinics, and insurance companies in the US may require a DSM diagnosis for all patients treated. The DSM can be used clinically, or to categorize patients using diagnostic criteria for research purposes. but they are correlated with the pharmaceutical corps to for profit purposes. Some studies done on specific disorders often recruit patients whose symptoms match the criteria listed in the DSM for that disorder. An international survey of psychiatrists in sixty-six countries compared the use of the ICD-10 and DSM-IV. It found the former was more often used for clinical diagnosis while the latter was more valued for research.[9]

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History

General

The initial impetus for developing a classification of mental disorders in the United States was the need to collect statistical information. The first official attempt was the 1840 census, which used a single category: "idiocy/insanity". Three years later, the American Statistical Association made an official protest to the U.S. House of Representatives, stating that "the most glaring and remarkable errors are found in the statements respecting nosology, prevalence of insanity, blindness, deafness, and dumbness, among the people of this nation", pointing out that in many towns African-Americans were all marked as insane, and calling the statistics essentially useless.

The Association of Medical Superintendents of American Institutions for the Insane was formed in 1844, changing its name in 1892 to the American Medico-Psychological Association, and in 1921 to the present American Psychiatric Association (**APA**).

Edward Jarvis and later Francis Amasa Walker helped expand the census, from two volumes in 1870 to twenty-five volumes in 1880. Frederick H. Wines was appointed to write a 582-page volume called *Report on the Defective, Dependent, and Delinquent Classes of the Population of the United States, As Returned at the Tenth Census (June 1, 1880)* (published 1888). Wines used seven categories of mental illness: dementia, dipsomania (uncontrollable craving for alcohol), epilepsy, mania, melancholia, monomania and paresis. These categories were also adopted by the Association.[11]

In 1917, together with the National Commission on Mental Hygiene (now Mental Health America), the APA developed a new guide for mental hospitals called the *Statistical Manual for the Use of Institutions for the Insane*. This included twenty-two diagnoses and would be revised several times by the APA over the years.[12] Along with the New York Academy of Medicine, the APA also provided the psychiatric nomenclature subsection of the US general medical guide, the *Standard Classified Nomenclature of Disease*, referred to as the *Standard*.[13]

DSM-I (1952)

World War II saw the large-scale involvement of US psychiatrists in the selection, processing, assessment, and treatment of soldiers. This moved the focus away from mental institutions and traditional clinical perspectives. A committee headed by psychiatrist Brigadier General William C. Menninger developed a new classification scheme called Medical 203, that was issued in 1943 as a

War Department Technical Bulletin under the auspices of the Office of the Surgeon General.[14] The foreword to the DSM-I states the US Navy had itself made some minor revisions but "the Army established a much more sweeping revision, abandoning the basic outline of the Standard and attempting to express present day concepts of mental disturbance. This nomenclature eventually was adopted by all Armed Forces", and "assorted modifications of the Armed Forces nomenclature [were] introduced into many clinics and hospitals by psychiatrists returning from military duty." The Veterans Administration also adopted a slightly modified version of Medical 203.

In 1949, the World Health Organization published the sixth revision of the International Statistical Classification of Diseases (ICD), which included a section on mental disorders for the first time. The foreword to DSM-1 states this "categorized mental disorders in rubrics similar to those of the Armed Forces nomenclature." An APA Committee on Nomenclature and Statistics was empowered to develop a version specifically for use in the United States, to standardize the diverse and confused usage of different documents. In 1950, the APA committee undertook a review and consultation. It circulated an adaptation of Medical 203, the VA system, and the Standard's Nomenclature to approximately 10% of APA members. 46% replied, of which 93% approved, and after some further revisions (resulting in its being called DSM-I), the Diagnostic and Statistical Manual of Mental Disorders was approved in 1951 and published in 1952. The structure and conceptual framework were the same as in Medical 203, and many passages of text were identical.[14] The manual was 130 pages long and listed 106 mental disorders.[15] These included several categories of "personality disturbance", generally distinguished from "neurosis" (nervousness; egodystonic).[16]

In 1952, the APA listed homosexuality in the DSM as a sociopathic personality disturbance. *Homosexuality: A Psychoanalytic Study of Male Homosexuals*, a large-scale 1962 study of homosexuality by Irving Bieber and other authors, was used to justify inclusion of the disorder as a supposed pathological hidden fear of the opposite sex caused by traumatic parent–child relationships. This view was very influential in the medical profession.[17] In 1956, however, the psychologist Evelyn Hooker performed a study comparing the happiness and well-adjusted nature of self-identified homosexual men with heterosexual men and found no difference.[18] Her study stunned the medical community and made her a heroine to many gay men and lesbians,[19] but homosexuality remained in the DSM until May 1974.[20]

DSM-II (1968)

In the 1960s, there were many challenges to the concept of mental illness itself. These challenges came from psychiatrists like Thomas Szasz, who argued mental illness was a myth used to disguise moral conflicts; from sociologists such as Erving Goffman, who said mental illness was another example of how society labels and controls non-conformists; from behavioural psychologists who challenged psychiatry's fundamental reliance on unobservable phenomena; and from gay rights activists who criticised the APA's listing of homosexuality as a mental disorder. A study published in *Science* by Rosenhan received much publicity and was viewed as an attack on the efficacy of psychiatric diagnosis.[21]

Although the APA was closely involved in the next significant revision of the mental disorder section of the ICD (version 8 in 1968), it decided to go ahead with a revision of the DSM. It was published in 1968, listed 182 disorders, and was 134 pages long. It was quite similar to the DSM-I. The term "reaction" was dropped, but the term "neurosis" was retained. Both the DSM-I and the DSM-II reflected the predominant psychodynamic psychiatry,[22] although they also included biological perspectives and concepts from Kraepelin's system of classification. Symptoms were not specified in detail for specific disorders. Many were seen as reflections of broad underlying conflicts or maladaptive reactions to life problems, rooted in a distinction between neurosis and psychosis (roughly, anxiety/depression broadly in touch with reality, or hallucinations/delusions appearing disconnected from reality). Sociological and biological knowledge was incorporated, in a model that did not emphasize a clear boundary between normality and abnormality.[23] The idea that personality disorders did not involve emotional distress was discarded.[16]

An influential 1974 paper by Robert Spitzer and Joseph L. Fleiss demonstrated the second edition of the DSM (DSM-II) was an unreliable diagnostic tool.[24] They found different practitioners using the DSM-II rarely agreed when diagnosing patients with similar problems. In reviewing previous studies of eighteen major diagnostic categories, Fleiss and Spitzer concluded "there are no diagnostic categories for which reliability is uniformly high. Reliability appears to be only satisfactory for three categories: mental deficiency, organic brain syndrome (but not its subtypes), and alcoholism. The level of reliability is no better than fair for psychosis and schizophrenia and is poor for the remaining categories".[25]

Sixth printing of the DSM-II, 1974

As described by Ronald Bayer, a psychiatrist and gay rights activist, specific protests by gay rights activists against the APA began in 1970, when the organization held its convention in San Francisco. The activists disrupted the conference by interrupting speakers and shouting down and ridiculing psychiatrists who viewed homosexuality as a mental disorder. In 1971, gay rights activist Frank Kameny worked with the Gay Liberation Front collective to demonstrate against the APA's convention. At the 1971 conference, Kameny grabbed the microphone and yelled: "Psychiatry is the enemy incarnate. Psychiatry has waged a relentless war of extermination against us. You may take this as a declaration of war against you."[26]

This activism occurred in the context of a broader anti-psychiatry movement that had come to the fore in the 1960s and was challenging the legitimacy of psychiatric diagnosis. Anti-psychiatry activists protested at the same APA conventions, with some shared slogans and intellectual foundations.[27][28]

Presented with data from researchers such as Alfred Kinsey and Evelyn Hooker, the sixth printing of the DSM-II, in 1974, no longer listed homosexuality as a category of disorder. After a vote by the APA trustees in 1973, and confirmed by the wider APA membership in 1974, the diagnosis was replaced with the category of "sexual orientation disturbance".[29]

DSM-III (1980)

In 1974, the decision to create a new revision of the DSM was made, and Robert Spitzer was selected as chairman of the task force. The initial impetus was to make the DSM nomenclature consistent with the International Statistical Classification of Diseases and Related Health Problems (ICD), published by the World Health Organization. The revision took on a far wider mandate under the influence and control of Spitzer and his chosen committee members.[30] One goal was to improve the uniformity and validity of psychiatric diagnosis in the wake of a number of critiques, including the famous Rosenhan experiment. There was also a need to standardize diagnostic practices within the US and with other countries after research showed psychiatric diagnoses differed between Europe and the US.[31] The establishment of these criteria was an attempt to facilitate the pharmaceutical regulatory process.

The criteria adopted for many of the mental disorders were taken from the Research Diagnostic Criteria (RDC) and Feighner Criteria, which had just been developed by a group of research-orientated psychiatrists based primarily at Washington University in St. Louis and the New York State Psychiatric Institute. Other criteria, and potential new categories of disorder, were established by consensus during meetings of the committee, as chaired by Spitzer. A key aim was to base categorization on colloquial English descriptive language (which would be easier to use by federal administrative offices), rather than assumptions of cause, although its categorical approach assumed each particular pattern of symptoms in a category reflected a particular underlying pathology (an approach described as "neo-Kraepelinian"). The psychodynamic or physiologic view was abandoned, in favor of a regulatory or legislative model. A new "multiaxial" system attempted to yield a picture more amenable to a statistical population census, rather than a simple diagnosis. Spitzer argued "mental disorders are a subset of medical disorders" but the task force decided on the DSM statement: "Each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome."[22] The personality disorders were placed on axis II along with mental retardation.[16]

The first draft of the DSM-III was prepared within a year. It introduced many new categories of disorder, while deleting or changing others. A number of the unpublished documents discussing and justifying the changes have recently come to light.[32] Field trials sponsored by the U.S. National Institute of Mental Health (NIMH) were conducted between 1977 and 1979 to test the reliability of the new diagnoses. A controversy emerged regarding deletion of the concept of neurosis, a mainstream of psychoanalytic theory and therapy but seen as vague and unscientific by the DSM task force. Faced with enormous political opposition, the DSM-III was in serious danger of not being approved by the APA Board of Trustees unless "neurosis" was included in some capacity; a political compromise reinserted the term in parentheses after the word "disorder" in some cases. Additionally, the diagnosis of ego-dystonic homosexuality replaced the DSM-II category of "sexual orientation disturbance".

Finally published in 1980, the DSM-III was 494 pages and listed 265 diagnostic categories. It rapidly came into widespread international use and has been termed a revolution or transformation in psychiatry.[22][23]

When DSM-III was published, the developers made extensive claims about the reliability of the radically new diagnostic system they had devised, which relied on data from special field trials. However, according to a 1994 article by Stuart A. Kirk:

> Twenty years after the reliability problem became the central focus of DSM-III, there is still not a single multi-site study showing that DSM (any version) is routinely used with high reliably by regular mental health clinicians. Nor is there any credible evidence that any version of the manual has greatly increased its reliability beyond the previous version. There are important methodological problems that limit the generalisability of most reliability studies. Each reliability study is constrained by the training and supervision of the interviewers, their motivation and commitment to diagnostic accuracy, their prior skill, the homogeneity of the clinical setting in regard to patient mix and base rates, and the methodological rigor achieved by the investigator ...[21]

DSM-III-R (1987)

In 1987, the DSM-III-R was published as a revision of the DSM-III, under the direction of Spitzer. Categories were renamed and reorganized, and significant changes in criteria were made. Six categories were deleted while others were added. Controversial diagnoses, such as pre-menstrual dysphoric disorder and masochistic personality disorder, were considered and discarded. "Ego-dystonic homosexuality" was also removed and was largely subsumed under "sexual disorder not otherwise specified", which can include "persistent and marked distress about one's sexual orientation."[22][33] Altogether, the DSM-III-R contained 292 diagnoses and was 567 pages long. Further efforts were made for the diagnoses to be purely descriptive, although the introductory text stated for at least some disorders, "particularly the Personality Disorders, the criteria require much more inference on the part of the observer" (p. xxiii).[16]

DSM-IV (1994)

In 1994, DSM-IV was published, listing 410 disorders in 886 pages. The task force was chaired by Allen Frances. A steering committee of twenty-seven people was introduced, including four psychologists. The steering committee created thirteen work groups of five to sixteen members. Each work group had about twenty advisers. The work groups conducted a three-step process: first, each group conducted an extensive literature review of their diagnoses; then, they requested data from researchers, conducting analyses to determine which criteria required change, with instructions to be conservative; finally, they conducted multicenter field trials relating diagnoses to clinical practice.[34][35] A major change from previous versions was the inclusion of a clinical significance criterion to almost half of all the categories, which required symptoms cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning". Some personality disorder diagnoses were deleted or moved to the appendix.[16]

DSM-IV-TR (2000)

A "text revision" of the DSM-IV, known as the DSM-IV-TR, was published in 2000. The diagnostic categories and the vast majority of the specific criteria for diagnosis were unchanged.[36] The text sections giving extra information on each diagnosis were updated, as were some of the diagnostic codes to maintain consistency with the ICD. The DSM-IV-TR was organized into a five-part axial system. The first axis incorporated clinical disorders. The second axis covered personality disorders and intellectual disabilities. The remaining axes covered medical, psychosocial, environmental, and childhood factors functionally necessary to provide diagnostic criteria for health care assessments.

The DSM-IV-TR characterizes a mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual [which] is associated with present distress ... or disability ... or with a significant increased risk of suffering." It also notes "no definition adequately specifies precise boundaries for the concept of 'mental disorder' ... different situations call for different definitions". It states "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder" (APA, 1994 and 2000).

DSM-IV-TR Categorization

The DSM-IV is a categorical classification system. The categories are prototypes, and a patient with a close approximation to the prototype is said to have that disorder. DSM-IV states, "there is no assumption each category of mental disorder is a completely discrete entity with absolute boundaries" but isolated, low-grade and non-criterion (unlisted for a given disorder) symptoms are not given importance.[37] Qualifiers are sometimes used, for example mild, moderate or severe forms of a disorder. For nearly half the disorders, symptoms must be sufficient to cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning", although DSM-IV-TR removed the distress criterion from tic disorders and several of the paraphilias due to their egosyntonic nature. Each category of disorder has a numeric code taken from the ICD coding system, used for health service (including insurance) administrative purposes.

DSM-IV-TR Multi-axial system

With the advent of the DSM-5 in 2013, the APA eliminated the longstanding multiaxial system for mental disorders.[38]

Previously, the DSM-IV organized each psychiatric diagnosis into five dimensions (axes) relating to different aspects of disorder or disability:

- ***Axis I****:* All psychological diagnostic categories except mental retardation and personality disorder
- ***Axis II****:* Personality disorders and mental retardation (more appropriately termed "intellectual disability")
- ***Axis III****:* General medical condition; acute medical conditions and physical disorders
- ***Axis IV****:* Psychosocial and environmental factors contributing to the disorder
- ***Axis V****:* Global Assessment of Functioning or Child Global Assessment of Functioning [cGAF]

Mental/Psychiatric/Behavioral/Learning conditions include, but are not limited to: depression, anxiety disorders, bipolar disorder, ADHD, autism spectrum disorders, anorexia nervosa, bulimia nervosa, and schizophrenia.

Personality Disorders include, but are not limited to: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, borderline personality disorder, antisocial personality disorder, narcissistic personality disorder, histrionic personality disorder, avoidant personality disorder, dependent personality disorder, obsessive-compulsive personality disorder; and organic intellectual disabilities.

Common medical/physical conditions or diseases that may result in and/or exacerbate some of the aforementioned mental/psychiatric conditions OR that may be aggravated by the aforementioned mental/psychiatric conditions include, but are not limited to: brain injuries, terminal diseases, pregnancy, cancer, epilepsy, idiopathic physiological conditions and virtually any other conditions, ailments and/or injuries which may affect the patient's mental health.. Many Biopsychosocial Assessments incorporate multiple factors that adversely affect the patient's, client's and/or subject's overall well-being and homeostasis.

Typical psychosocial influences that are usually listed as having negative impact on life, mentality and health include, but are not limited to: Environmental factors of dysfunction such as those experienced within home, school and work; Social factors such as issues with drug use (not diagnosed), enabling friends and conflicts with coworkers; Family complications such as divorce, social service involvement and court ordered placements; Various stressors such as recent accident, natural disaster and other traumatic occurrences (i.e. assault, death, abuse); Financial problems such as bankruptcy, job loss and debts; and service needs such as lack of medical insurance, inability to find adequate treatment and inaccessibility to necessary state and federal programs.

Sourcebooks

The DSM-IV does not specifically cite its sources, but there are four volumes of "sourcebooks" intended to be APA's documentation of the guideline development process and supporting evidence, including literature reviews, data analyses and field trials.[39][40][41][42] The Sourcebooks have been said to provide important insights into the character and quality of the decisions that led to the production of DSM-IV, and hence the scientific credibility of contemporary psychiatric classification.[43][44]

DSM-5 (2013)

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the DSM-5, was approved by the Board of Trustees of the APA on December 1, 2012.[45] Published on May 18, 2013,[46] the DSM-5 contains extensively revised diagnoses and, in some cases, broadens diagnostic definitions while narrowing definitions in other cases.[47] The DSM-5 is the first major edition of the manual in twenty years.[48]

A significant change in the fifth edition is the deletion of the subtypes of schizophrenia (paranoid, disorganized, catatonic, undifferentiated and residual).[49]

The deletion of the subsets of autistic spectrum disorder (namely, Asperger's syndrome, classic autism, Rett syndrome, childhood disintegrative disorder and pervasive developmental disorder not otherwise specified) was also implemented, with specifiers with regard to intensity (mild, moderate and severe). Severity is based on social communication impairments and restricted, repetitive patterns of behaviour, with three levels: 1 (requiring support), 2 (requiring substantial support) and 3 (requiring very substantial support).

During the revision process, the APA website periodically listed several sections of the DSM-5 for review and discussion.[50]

Future revisions and updates

Beginning with the fifth edition, it is intended diagnostic guidelines revisions will be added more often to keep up with research in the field.[51] It is notable the DSM-5 is identified with Arabic rather than Roman numerals. Beginning with DSM-5, the American Psychiatric Association will use decimals to identify incremental updates (e.g., DSM-5.1, DSM-5.2) and whole numbers for new editions (e.g., DSM-5, DSM-6),[52] similar to the scheme used for software versioning

Criticism

Reliability and validity concerns

The revisions of the DSM from the 3rd Edition forward have been mainly concerned with diagnostic reliability—the degree to which different diagnosticians agree on a diagnosis. {Henrik Walter} argued that a science of psychiatry can only advance if diagnosis is reliable. If clinicians and researchers frequently disagree about the diagnosis of a patient, then research into the causes and effective treatments of those disorders cannot advance. Hence, diagnostic reliability was a major concern of DSM-III. When the diagnostic reliability problem was thought to be solved, subsequent editions of the DSM were concerned mainly with "tweaking" the diagnostic criteria. Unfortunately, neither the issue of reliability or validity was settled.[53]

In 2013, shortly before the publication of DSM-5, the Director of the National Institute of Mental Health (NIMH), Thomas R. Insel, declared that the agency would no longer fund research projects that rely exclusively on DSM diagnostic criteria due to its lack of validity.[54] Insel questioned the validity of the DSM classification scheme because "... diagnoses are based on a consensus about clusters of clinical symptoms ...." as opposed to "... collecting the genetic, imaging, physiologic, and cognitive data to see how all the data – not just the symptoms – cluster and how these clusters relate to treatment response.[55][56]

Field trials of DSM-5 brought the debate of reliability back into the limelight as some disorders showed poor reliability. For example, major depressive disorder, a common mental illness, had a poor reliability kappa statistic of 0.28, indicating that clinicians frequently disagreed on this diagnosis in the same patients. The most reliable diagnosis was major neurocognitive disorder with a kappa of 0.78.[57]

Superficial symptoms

By design, the DSM is primarily concerned with the signs and symptoms of mental disorders, rather than the underlying causes. It claims to collect them together based on statistical or clinical patterns. As such, it has been compared to a naturalist's field guide to birds, with similar advantages and disadvantages.[58] The lack of a causative or explanatory basis, however, is not specific to the DSM, but rather reflects a general lack of pathophysiological understanding of psychiatric disorders. As DSM-III chief architect

Robert Spitzer and DSM-IV editor Michael First outlined in 2005, "little progress has been made toward understanding the pathophysiological processes and cause of mental disorders. If anything, the research has shown the situation is even more complex than initially imagined, and we believe not enough is known to structure the classification of psychiatric disorders according to etiology."[59]

"The DSM's focus on superficial symptoms is claimed to be largely a result of necessity (assuming such a manual is nevertheless produced), since there is no agreement on a more explanatory classification system. Reviewers note, however, that this approach is undermining research, including in genetics, because it results in the grouping of individuals who have very little in common except superficial criteria as per DSM or ICD diagnosis (Fadul, 2014, p.143)."[5][60]

Despite the lack of consensus on underlying causation, advocates for specific psychopathological paradigms have nonetheless faulted the current diagnostic scheme for not incorporating evidence-based models or findings from other areas of science. A recent example is evolutionary psychologists' criticism that the DSM does not differentiate between genuine cognitive malfunctions and those induced by psychological adaptations, a key distinction within evolutionary psychology but one that is widely challenged within general psychology.[61][62][63] Another example is the strong operationalist viewpoint, which contends that reliance on operational definitions, as purported by the DSM, necessitates that intuitive concepts like depression be replaced by specific measurable concepts before they are scientifically meaningful. One critic states of psychologists that "Instead of replacing 'metaphysical' terms such as 'desire' and 'purpose', they used it to legitimize them by giving them operational definitions ... the initial, quite radical operationalist ideas eventually came to serve as little more than a 'reassurance fetish' (Koch 1992) for mainstream methodological practice."[64]

A 2013 review published in the *European Archives of Psychiatry and Clinical Neuroscience* states "that psychiatry targets the phenomena of consciousness, which, unlike somatic symptoms and signs, cannot be grasped on the analogy with material thing-like objects." As an example of the problem of the superficial characterization of psychiatric signs and symptoms, the authors gave the example of a patient saying they "feel depressed, sad, or down", showing that such a statement could indicate various underlying experiences: "not only depressed mood but also, for instance, irritation, anger, loss of meaning, varieties of fatigue, ambivalence, ruminations of different kinds, hyper-reflectivity, thought pressure, psychological anxiety, varieties of depersonalization, and even voices with negative content, and so forth." The structured interview comes with "danger of over confidence in the face value of the answers, as if a simple 'yes' or 'no' truly confirmed or denied the diagnostic criterion at issue." The authors gave an example: A patient who was being administered the Structured Clinical Interview for the DSM-IV Axis I Disorders denied thought insertion, but during a "conversational, phenomenological interview", a semi-structured interview tailored to the patient, the same patient admitted to experiencing thought insertion, along with a delusional elaboration. The authors suggested 2 reasons for this discrepancy: either the patient did not "recognize his own experience in the rather blunt, implicitly either/or formulation of the structured-interview question", or the experience did not "fully articulate itself" until the patient started talking about his experiences.[65]

Overdiagnosis

Dr. Allen Frances being an outspoken critic of the DSM-5 states that "normality is an endangered species," for the reason of "fad diagnoses" and an "epidemic" of over-diagnosing, and suggests that the "DSM-5 threatens to provoke several more [epidemics]."[66][67] Some researchers state that changes in diagnostic criteria reduce thresholds for a diagnosis, which results in increases in prevalence rates following each published version of the DSM for ADHD[68][69][70] and autism spectrum disorder.[71] Bruchmüller suggests that as a factor that may lead to overdiagnosis can be also situations when the diagnostician's clinical judgment regarding a diagnose (ADHD) is afected by heuristics.[69]

Dividing lines

Despite caveats in the introduction to the DSM, it has long been argued that its system of classification makes unjustified categorical distinctions between disorders and uses arbitrary cut-offs between normal and abnormal. A 2009 psychiatric review noted that attempts to demonstrate natural boundaries between related DSM syndromes, or between a common DSM syndrome and normality, have failed.[5] Some argue that rather than a categorical approach, a fully dimensional, spectrum or complaint-oriented approach would better reflect the evidence.[72][73][74]

In addition, it is argued that the current approach based on exceeding a threshold of symptoms does not adequately take into account the context in which a person is living, and to what extent there is internal disorder of an individual versus a psychological response to adverse situations.[75][76] The DSM does include a step ("Axis IV") for outlining "Psychosocial and environmental factors contributing to the disorder" once someone is diagnosed with that particular disorder.

Because an individual's degree of impairment is often not correlated with symptom counts and can stem from various individual and social factors, the DSM's standard of distress or disability can often produce false positives.[77] On the other hand, individuals who do not meet symptom counts may nevertheless experience comparable distress or disability in their life.

Cultural bias

Psychiatrists have argued that published diagnostic standards relied on an exaggerated interpretation of neurophysiological findings and so understate the scientific importance of social-psychological variables.[78] Advocating a more culturally sensitive approach to psychology, critics such as Carl Bell and Marcello Maviglia contend that researchers and service-providers often discount the cultural and ethnic diversity of individuals.[79] In addition, current diagnostic guidelines have been criticized as having a fundamentally Euro-American outlook. Although these guidelines have been widely implemented, opponents argue that even when a diagnostic criterion-set is accepted across different cultures, it does not necessarily indicate that the underlying constructs have any validity within those cultures; even reliable application can only demonstrate consistency, not legitimacy.[78] Cross-cultural psychiatrist Arthur Kleinman contends that the Western bias is ironically illustrated in the introduction of cultural factors to the DSM-IV: the fact that disorders or concepts from non-Western or non-mainstream cultures are described as "culture-bound", whereas standard psychiatric diagnoses are given no cultural qualification whatsoever, is to Kleinman revelatory of an underlying assumption that Western cultural phenomena are universal.[80] Other cross-cultural critics largely share Kleinman's negative view toward the culture-bound syndrome, common responses included both disappointment over the large number of documented non-Western mental disorders still left out, and frustration that even those included were often misinterpreted or misrepresented.[81]

Mainstream psychiatrists have also been dissatisfied with these new culture-bound diagnoses, although not for the same reasons. Robert Spitzer, a lead architect of the DSM-III, has held the opinion that the addition of cultural formulations was an attempt to placate cultural critics, and that they lack any scientific motivation or support. Spitzer also posits that the new culture-bound diagnoses are rarely used in practice, maintaining that the standard diagnoses apply regardless of the culture involved. In general, the mainstream psychiatric opinion remains that if a diagnostic category is valid, cross-cultural factors are either irrelevant or are only significant to specific symptom presentations.[78] One of the results was the development of the Azibo Nosology by Daudi Ajani Ya Azibo as an alternative to the DSM to treat African and African American patients.[82][83][84]

Historically, the DSM tended to avoid issues involving religion; the DSM-5 relaxed this attitude somewhat.[85]

Medicalization and financial conflicts of interest

There was extensive analysis and comment on DSM-IV (published in 1994) in the years leading up to the 2013 publication of DSM-5. It was alleged that the way the categories of DSM-IV were structured, as well as the substantial expansion of the number of categories within it, represented increasing medicalization of human nature, very possibly attributable to disease mongering by psychiatrists and pharmaceutical companies, the power and influence of the latter having grown dramatically in recent decades.[86] In 2005, then APA President Steven Sharfstein released a statement in which he conceded that psychiatrists had "allowed the biopsychosocial model to become the bio-bio-bio model".[87] A 2006 article[88] reported that of the authors who selected and defined the DSM-IV psychiatric disorders, roughly half had financial relationships with the pharmaceutical industry during the period 1989-2004, raising the prospect of a direct conflict of interest. The same article concluded that the connections between panel members and the drug companies were particularly strong in those diagnoses where drugs are the first line of treatment, such as schizophrenia and mood disorders, where 100% of the panel members had financial ties with the pharmaceutical industry.

William Glasser referred to DSM-IV as "phony diagnostic categories", arguing that "it was developed to help psychiatrists – to help them make money".[89] A 2012 New York Times article commented sharply that DSM-IV (then in its 18th year), through copyrights held closely by the APA, had earned the Association over $100 million.[90]

However, although the number of identified diagnoses had increased by more than 300% (from 106 in DSM-I to 365 in DSM-IV-TR), psychiatrists such as Zimmerman and Spitzer argued that this almost entirely represented greater specification of the forms of pathology, thereby allowing better grouping of more similar patients.[5]

Clients, survivors, and consumer

A client is a person who accesses psychiatric services and may have been given a diagnosis from the DSM, while a survivor self-identifies as a person who has endured a psychiatric intervention and the mental health system (which may have involved involuntary commitment and involuntary treatment). A term adopted by many users of psychiatric services is "consumer." This term was chosen to eliminate the "patient" label and restore the person to an active role as a user or consumer of services.[91] Some individuals are relieved to find that they have a recognized condition that they can apply a name to and this has led to many people self-diagnosing. Others, however, question the accuracy of the diagnosis, or feel they have been given a "label" that invites social stigma and discrimination (the terms "mentalism" and "sanism" have been used to describe such discriminatory treatment).[92]

Diagnoses can become internalized and affect an individual's self-identity, and some psychotherapists have found that the healing process can be inhibited and symptoms can worsen as a result.[93] Some members of the psychiatric survivors movement (more broadly the consumer/survivor/ex-patientmovement) actively campaign against their diagnoses, or the assumed implications, and/or against the DSM system in general.[94][95] Additionally, it has been noted that the DSM often uses definitions and terminology that are inconsistent with a recovery model, and such content can erroneously imply excess psychopathology (e.g. multiple "comorbid" diagnoses) or chronicity.[95]

DSM-5 critiques

Psychiatrist Allen Frances has been critical of proposed revisions to the DSM-5. In a 2012 *New York Times* editorial, Frances warned that if this DSM version is issued unamended by the APA, "it will medicalize normality and result in a glut of unnecessary and harmful drug prescription."[96] In a December 2, 2012 blog post in *Psychology Today*, Frances provides his "... list of DSM 5's ten most potentially harmful changes":[97]

- Disruptive Mood Dysregulation Disorder, for temper tantrums
- Major Depressive Disorder, includes normal grief
- Minor Neurocognitive Disorder, for normal forgetting in old age
- Adult Attention Deficit Disorder, encouraging psychiatric prescriptions of stimulants
- Binge Eating Disorder, for excessive eating
- Autism, defining the disorder more specifically, possibly leading to decreased rates of diagnosis and the disruption of school services
- First time drug users will be lumped in with addicts
- Behavioral Addictions, making a "...mental disorder of everything we like to do a lot."[97]
- Generalized Anxiety Disorder, includes everyday worries
- Post-traumatic stress disorder, changes "... opened the gate even further to the already existing problem of misdiagnosis of PTSD in forensic settings."[97]

Frances and others have published debates on what they see as the six most essential questions in psychiatric diagnosis:[98]

- are they more like theoretical constructs or more like diseases
- how to reach an agreed definition
- whether the DSM-5 should take a cautious or conservative approach
- the role of practical rather than scientific considerations
- the issue of use by clinicians or researchers
- whether an entirely different diagnostic system is required.

In 2011, psychologist Brent Robbins co-authored a national letter for the Society for Humanistic Psychology that has brought thousands into the public debate about the DSM. Over 15,000 individuals and mental health professionals have signed a petition in support of the letter.[99] Thirteen other American Psychological Association divisions have endorsed the petition.[100] Robbins has

noted that under the new guidelines, certain responses to grief could be labeled as pathological disorders, instead of being recognized as being normal human experiences.[101]

See also

- Chinese Classification and Diagnostic Criteria of Mental Disorders
- Classification of mental disorders
- Diagnostic classification and rating scales used in psychiatry
- DSM-IV Codes
- Global Assessment of Functioning (GAF) Scale
- International Statistical Classification of Diseases and Related Health Problems (ICD)
- Kraepelinian dichotomy
- Psychodynamic Diagnostic Manual
- Relational disorder (proposed DSM-5 new diagnosis)
- Research Domain Criteria (RDoC), a framework being developed by the National Institute of Mental Health
- Rosenhan experiment
- Structured Clinical Interview for DSM-IV *(SCID)*
- Homosexuality in DSM

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Further reading

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External links

- Official DSM-5 development website
- Diagnostic Criteria from DSM-IV-TR
- Cooper, Rachel (2017): Diagnostic and Statistical Manual of Mental Disorders (DSM). ISKO Encyclopedia of Knowledge Organization
- The Multiaxial System of Diagnosis in DSM-IV Criteria

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